STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

Client's Name: _____ DOB: _____
Client's Address: _____ SS#: _____
_____

I authorize The Rhode Island Department of Children, Youth and Families to:
OBTAIN FROM: Name: _____
Address: _____
_____

The following information contained in records pertaining to services provided on or about
(Start Date) _____ (End Date) _____
Please check the appropriate information to be released:

☐ discharge summary	☐ financial	☐ substance abuse treatment
☐ psychiatric evaluation	☐ housing	☐ laboratory data
☐ assessment/progress notes	☐ educational	☐ HIV/AIDS data
☐ treatment/case plan	☐ psychological tests	_____
☐ medical	☐ other (be specific)	_____

Information can be released via: (*check all that apply*)
☐ **fax** ☐ **written materials** ☐ **electronic mail** ☐ **telephone** ☐ **direct contact** ☐ **other (be specific)**

This information is needed for the following purpose (s):
☐ Case assessment/investigation ☐ Ongoing services ☐ Other (be specific) _____

I understand that my records are processed under RI General Law and **cannot be disclosed without my written consent except as otherwise specifically provided by law**. I also understand that if my records involve alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under **Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23**.

I release the Rhode Island Department of Children, Youth and Families (DCYF) and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This consent will have a duration of **no longer than one (1) year from the date of this form**. I understand that **I may withdraw my consent (in writing to _____) at any time except to the extent that action has been taken in reliance on it**.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to receive services from DCYF. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information (including HIV test results and alcohol and drug abuse records if checked above) to those persons/agencies named above.

_____ _____ _____
Signature of Client/Legal Guardian or Parent Relationship to Client Date Signed

_____ _____
Witness Signature Date Signed